Models of Physician-Assisted Dying

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Repeated surveys have shown that more than 70% of Americans support physician aid in dying for terminally ill mentally competent adults.[1] Recent polls of physicians in Oregon[2] and Michigan[3] demonstrate majority support of those doctors for such a law while 25% of physicians surveyed in Washington admitted to already providing help.[4] Models of how that would work have been spelled out in proposed legislation in the United States since 1988;[5] other models come from the Northern Territory in Australia,[6] from Holland,[7] and from Jack Kevorkian's writing[8] and actions as well as from other writers such as Dr Timothy Quill.[9]

In this article I will review some of the main features of these models in an effort to find common elements. In July the U.S. Supreme Court will decide on the constitutionality of this issue; it is likely they will turn it back to the states or the voters to develop guidelines. It is, therefore, helpful to examine the elements that could be included in future proposals.

Holland, of course, is the oldest model having evolved over 23 years of judicial guidelines. The scope of assisted dying is not limited to the terminally ill but includes hopelessly ill people, a tiny minority of whom have had psychiatric conditions which they and their doctors see as hopeless. A small number of patients who received help were not competent and the assistance was provided at the request of the family or on a decision by the physician who had known the patient's wishes. Usually the patient is mentally competent. Assistance is sometimes provided to minors.

Doctors will not be prosecuted if they observe the following guidelines:[10]

1. The request must come from the patient; it must be made freely and voluntarily
2. The request must be well-informed and considered
3. The request must have been made over a period of time
4. The patient must experience unacceptable and hopeless suffering which cannot be satisfactorily relieved
5. The doctor must consult with a second doctor to confirm the decision
6. Only a doctor can assist and must be present

The method is either through lethal injection or a lethal dose of medication self-administered; the death usually occurs at home. The doctor is present as is the family and often a nurse and a clergyman. In the hospital a team of two doctors, a nurse, and a spiritual caregiver evaluate the request.

Doctors report the death to the local medical examiner with comprehensive details covered in a 60 item questionnaire. The coroner views the body, verifies the facts and files a report to the public prosecutor. An investigation occurs if the guidelines do not appear to have been followed, which is relatively rare. Not every request is honored; the Members Aid Society of the Dutch Voluntary Euthanasia Society helps match patients with doctors when there is no help available.

Palliative care is integrated into the delivery of health care generally. Dr Peter Admiraal , a noted Dutch physician who has been assisting patients in a Delft hospital since 1973, notes that to "fail to practice voluntary euthanasia under some circumstances is to fail the patient."[11] He regards it as "the last dignified act of terminal care."[11] The majority of the Dutch population supports the practice although it is not governed by an actual law.

The Northern Territory in Australia is the only jurisdiction in the world in which physician aid is dying occurs under a law, the Rights of the Terminally Ill Act, which went into effect July 1, 1996. The first person in the world to die using voluntary euthanasia legislation was Bob Dent, a 66 year old prostate cancer patient who was helped to die at his home by Dr Philip Nitschke on September 21 with Mrs. Dent present.

Terminal illness is a requirement as defined as one that will lead to death. The competent, adult patient who makes the request must have the diagnosis and prognosis confirmed by the treating physician and by a specialist in the disease. In addition, there must be a psychiatric evaluation certifying the competency to make the decision and an absence of clinical depression. There is a nine-day waiting period after the initial request. Although the law does not require it, Mr. Dent died from a self-administered lethal dose of barbiturates administered by a machine invented by Dr Nitschke. The physician inserts the IV then the patient pushes the button starting the lethal drip after answering three questions on a laptop computer. Death occurs in a few minutes.

There is an effort to rescind this law in Australia; Dr Nitschke has had difficulty finding specialists because of the opposition of the Australian Medical Association. In a letter to members of the Australian parliament a few days before he died Mr. Dent, in describing his deteriorating condition over five years, wrote, "If I were to keep a pet animal in the same condition I am in, I would be prosecuted." Dr Nitschke said, "...I was left with the overwhelming feeling that I had done the right thing, done something good by being able to end the suffering of this brave man."[12]

The Oregon Death with Dignity Bill was passed by 51% of Oregon voters in November 1994. At this writing no deaths have occurred because of an injunction issued by Judge Michael Hogan at the instigation of the National Right to Life Committee. Were it to go into effect it would apply only to terminally ill, mentally competent adults. Doctors would only be allowed to assist by prescribing a lethal dose of medication to be self-administered by the patient. Safeguards include: a written, witnessed directive; examination by an independent physician; an optional request by the treating physician for a psychological or psychiatric evaluation to determine the patient's competence; and reporting by the hospital to the State Department of Human Resources without using the patient's name. The doctor does not have to be present. The appeal of the judicial injunction will be heard by the 9th Circuit Court of Appeal.[13]

Dr Jack Kevorkian is apparently engaged in legal aid in dying in more than 40 cases since he has been acquitted three times in five deaths and is not currently being prosecuted. He has helped competent terminally and hopelessly ill adults who are suffering greatly or, in the case of his first patient, Janet Adkins, anticipate a greatly reduced quality of life and incompetence, and who make the request. There is some question about the subjective quality of the suffering in a few cases but Dr Kevorkian has not been able to use consultants and is not a treating physician.

He has used a "suicide machine" in which he puts an IV in the person's arm then the patient her/himself actually starts the lethal medication. Since he lost his license, Kevorkian has mostly used carbon monoxide. The patient tapes an interview with Kevorkian and a family member is generally present. Recently there have been other health care professionals present and with whom Kevorkian apparently consults. In his book, Kevorkian proposes another model in which physicians are trained as obitiatrists; a patient could go to an obitorium in which requests are screened and medicide is administered.[8]

A thoughtful article in the **Harvard Journal of Legislation**[14] in the Winter of 1996 by nine authors proposed guidelines for a model state act to authorize and regulate physician-assisted suicide. They recommend a prescribing-only model because it accentuates the voluntariness of the patient's decision and it would be more acceptable to the public.

Those eligible would have an incurable illness and subjectively feel that the accompanying suffering is worse than death. There should not have to be a demonstration that the suffering is unbearable. Because the person would have to be competent, someone who is clinically depressed or mentally ill would not qualify. The request must be stated to the physician on at least two occasions that are at least two weeks apart. Information is supplied to the patient in the presence of two witnesses. The physician is allowed but not required to be present at the time of death. The physician's report is confidential and the patient's name is not used.

The decisions of the **9th and 2nd Circuit Courts of Appeal** have declared that state assisted suicide laws which prohibit doctors from helping competent terminally ill patients die by prescribing a lethal prescription of medication are unconstitutional. The Supreme Court has agreed to hear the appeals of these decisions in January, 1997, and to give an opinion in July. They may accept the constitutionality of physician aid in dying and allow the states to draft the safeguards and conditions.

These are just a few of the proposed models from the United States and elsewhere. It is now a question of what form the legalization of physician aid in dying takes and when, not if, it will be permitted. The issues are whether only terminally ill patients would be eligible, as in the Supreme Court cases, or whether it would extend to hopeless illnesses. A doctor may be able to provide direct help (voluntary euthanasia) or just give the patient the means to accomplish it (physician assisted suicide.) The Supreme Court will hear the prescribing only model. The mandatory or optional use of a mental health professional's evaluation will probably be decided in each state's statute. It is likely that two independent doctors will have to evaluate the patient, that there will be a witnessed written request followed by a waiting period, and that the patient will be required to be competent (at least at the time of the first, witnessed request.) In all cases participation of the doctor and the patient would be voluntary; a hospital will probably be able to refuse to have this procedure administered.

The process from a physician's point of view is summarized by Australian urologist, Dr Rodney Syme:

Medical assistance in suicide means that the doctor assists patients with advice, and through the prescription of drugs, enables them to end their lives in a dignified way. This involves the doctor in dialogue to inform the patients of their diagnosis prognosis and treatment options. It involves ensuring that suffering in each case is significant and unalterable, that the patient is rational and not under duress, and that the request is sound and enduring....If the doctor is satisfied beyond reasonable doubt of the bona fides of the request then she or he should be able, after confirmation of the facts by a second doctor, to proceed to assistance without threat of legal sanction.[15]

Or, to quote Dr Timothy Quill:

By exploring our hopes and fears about our own death, and by listening and learning from the stories about those who have directly faced death, we will hope to learn how to use medicine's power judiciously to achieve two of its most important objectives: prolonging a meaningful life and humanizing the process of dying.[16]

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Editors Note:

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She has served on the Boards of several ACLU affiliates, was the founder and president of a nationwide professional organization Psychologists in Addictive Behavior — and is Past President of the San Diego Psychology-Law Society.

Her interest in the right to die began in 1983 she was asked to evaluate Elizabeth Bouvia — a young quadriplegic woman who wanted the right to refuse food at Riverside Hospital.

In 1987 she founded and became the first president of the Hemlock Society of San Diego and editor of their Newsletter, offices she held for nine years. She has written articles on the right to die for medical, legal and psychological journals and has appeared on national TV and radio speaking on the right to die.